ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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January, 1961

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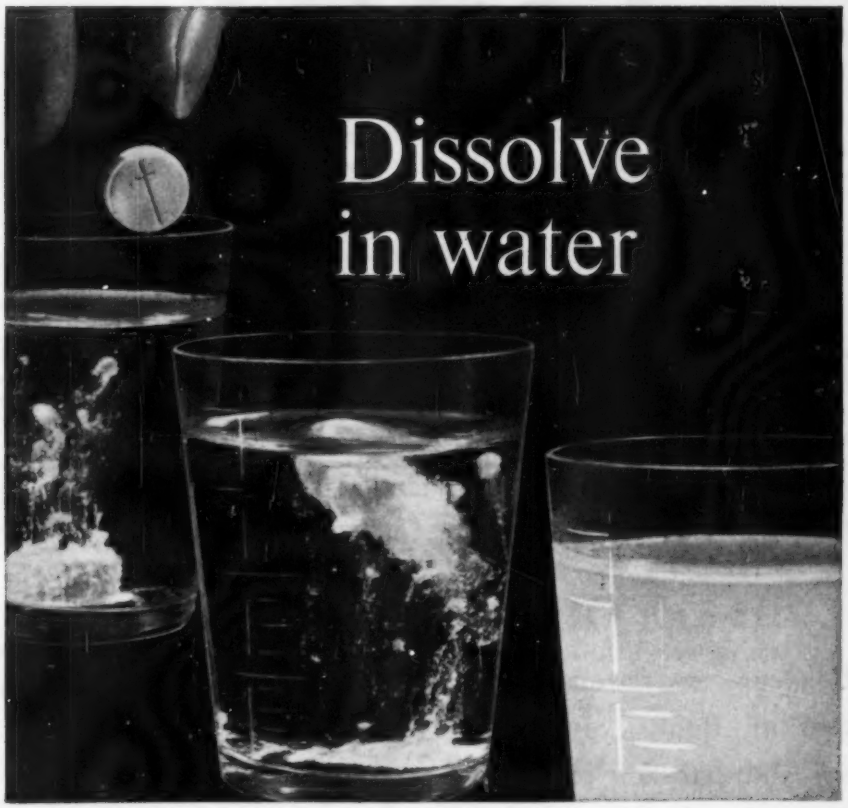

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 1 JANUARY, 1961

Calendar

JANUARY

Sat. 7—On duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen

Sat. 14—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine

Sat. 21—On Duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton Hewer

Mon. 23—Film Society: "Hiroshima mon Amour".

Thurs. 26—Abernethian Society: Dr. Carstairs.

Sat. 28—On Duty: Medical and Surgical Units
Mr. George Ellis

FEBRUARY

Sat. 4—On Duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans

Mon. 6—Film Society: "The Naked Truth".

Sat. 11—On Duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen

Editorial

THERE ARE A great many views, held individually, on what the Journal is, and what it should be; and yet few of our critics, when questioned, seem fully to understand the purpose of this publication.

It has been suggested that these pages could carry a little more humour, but the Journal is no medical equivalent of *Punch*, and it is certainly not part of our policy to swamp it with the various forms of humour which may be gathered from the resources at our disposal. Humorous articles and poems, however, do appear in sensibly balanced proportion, and either pertain to a matter of domestic interest, or are submitted for publication by some very welcome contributor.

A second suggestion is "that we include more articles of educational value", yet just as we do not wish to upset the balance by overloading the Journal with humour, so neither do we wish to tip it the other way. The articles published are of general medical interest, and although they will further our knowledge, they are not primarily intended to assist the examination candidate.

The final suggestion is that the Journal broadens its scope, but here it is necessary to

mention one or two points of policy. The principal aims of the Journal are: firstly to cover the domestic affairs of the Hospital and Medical College, secondly to provide articles on topics of general interest to us all, and thirdly to serve as a link with the Hospital for those who have left. These functions are accomplished by the Journal as it is, and a further broadening of scope would inevitably mean the introduction of material irrelevant to the Hospital and ourselves, and it is over questions like this that the Journal must maintain an adequate sense of proportion.

Great use has been made recently of the phrase "A wind of change" and the blasts and hurricanes of Africa and the Far East have been matched in this country by a gentle zephyr rustling the scattered papers in the Journal Office. In short it has been decided to change the printers. As a result of this change, it is hoped to bring the Journal up to date so that it is published during the month for which it is current. The Editor would like to take this opportunity to apologise to contributors and readers alike for the unfortunate delays which have so marred our publication in the past. *A propos* of this, it would greatly assist the editorial staff if all who contribute reports on club and social activities ensured that these reports are forwarded in good time for publication.

Fifty years ago

ON MONDAY, DECEMBER 5th, 1910, a General Meeting of the Students' Union was held for the purpose of discussing a question which was of vital importance to the continued prosperity of the British Empire. A large number of members were present, and Mr. Waring, President of the Students' Union, kindly consented to take the chair. The subject of the discussion was: "That in the opinion of this meeting the continuance of the present Liberal policy will lead to the ruin of the Empire".

It may be remarked that, although gentlemen of conflicting opinions on this academic topic sat upon different sides of the room, the proceedings throughout were conducted with a mild and broad-minded bon-homie, and that the party spirit that might easily have been much in evidence during a general election seemed to be remote from the thoughts of the various speakers, whose wholesome probing after truth showed that they, at least, had not been drawn into the vortex of Party politics.

Mr. Morse, in opening, said that greatness was thrust upon him. He could not go into details, but the combined "Liberal-Radical-Socialist-what-not" policy was disruptive and almost anarchy. If all were equal today, all would be as before tomorrow. Socialism, an impossibility, must end in dictatorship.

Mr. Barrow, in seconding, said that the lower classes did not hate the upper classes and were polite to him. Single chamber is impossible, as any government could pass any law it liked, which could be reversed by the opposition when in power. United States had a strong second chamber.

Mr. Baynes, the opposer, spoke of the agile change of the Unionist front, and quoted the Referendum. Democracy is an important thing, to be trusted and not to be exploited by the House of Lords. Free Trade and Home Rule were necessarily fundamental propositions to the Liberal policy.

Mr. Molony, who seconded Mr. Baynes, deplored the mistrust of Ireland by England after one hundred years of union. He said that the Government of Ireland was wasteful in police and judiciary, and parsimonious in education and public health.

Mr. Hill, a historian, stated that England was greatest when England was drunk.

Mr. Snowdon said that theoretically, Socialism was excellent; practically an impossibility.

Mr. Strahan quoted Referendum, House of Lords, Bills (various), trams and gas (municipal).

Mr. Russell attempted to address the meeting, became "political", and sat down.

Mr. Wedd assured us that the whole Liberal policy was destructive and non-imperial. "Unity (and Tory Government) is strength."

Mr. Nicholson, our railway expert, quoted statistics. There were a number of other speakers.

Mr. Baynes, in replying, became poetical and mystic, and talked of "the great stream of Socialism flowing through a dam of Peers."

Mr. Morse, in replying, said that democracy cannot govern; "it's breeding" that counts. He ended with a few verses of Kipling.

On a show of hands the motion was found to be carried. The meeting then adjourned.

Abernethian Society

ON OCTOBER 25TH, 1960, Prof. R. A. McCance, F.R.S., Prof., Experimental Medicine, Cambridge University, addressed the society on: "Thermal Stability in the Neonate and Adult".

He introduced his subject with a summary of the physiology of heat production and loss. Heat production results from muscular activity, basal metabolic rate and thermo-regulatory heat production. It is, in fact, a result of cellular activity, derived from wastage in the synthesis of adenosine tri-phosphate. Heat loss in human beings occurs through the lungs and direct from the skin—we rely mainly on our subcutaneous fat for conservation of heat.

Recent experiments on mice and pigs were explained. Heat production is at a minimum at the critical temperature but it increases as the temperature is lowered. Nor-adrenaline may mediate this response. It was observed that the oxygen consumption increased during cooling and that injections of nor-adrenaline had the same effect only during cooling.

Piglets when cooled, use up their glycogen stores because hypoglycaemic fits will result if they are warmed up while in this state. We are to deduce from this, therefore, that cold newborn infants are also hypoglycaemic. A well meaning nurse would endeavour to warm them up and thus unwittingly induce convulsions. It would be better, first, to treat the hypoglycaemia and acidosis, and then, the neonate will be better able to return to a normal temperature.

T. G. H.

ON NOVEMBER 10TH, Prof. W. S. Peart, Prof. of Medicine at St. Mary's Hospital, addressed the society on: "Hypertension". His talk, illustrated by slides, included many interesting experiments, but he found it difficult to assess their significance:—

A rise of blood pressure is caused more by an increase in peripheral resistance than by the cardiac output. Referring to his recent work on hypertension due to atheromatous renal artery stenosis, he suggests all loins should be stamped: "Kidneys not to be sacrificed"—an arterial graft gives better results. Histology reveals the arterial obstruction within the kidneys often leaves the glomeruli intact and damaging only the tubules. Removal of a Phaeochromacytoma is not so good in lowering blood pressure. The I.V.P. of a diseased kidney in hypertension is often deceptive. It will excrete the dye less effectively than its normal partner, thus exhibiting a much greater concentration of the dye. Usually, one is tempted to assume that the kidney showing less dye is at fault, but in this instance it is not. Work on the carotid sinus showed it to be adaptable to the general blood pressure. It is effective in lowering small increments of pressure and this property remains, however high the general pressure may be.

Prof. Peart thought hypertension was a phenomenon of the body resulting because there was no mechanism to stop it. After all his work on the kidney, he remains sure that this organ secretes the hormone primarily concerned in changes of general blood pressure—though it has still not yet been identified satisfactorily.

T.G.H.

The result of the elections for the coming season were as follows:

President	J. C. CRAWHALL
Secretary	P. J. WATKINS
Treasurer	H. WHITE
Committee	M. BALL
	T. G. HUDSON
	A. J. B. MISSEN
Pre-Clinical Representative	M. LIPSEDGE

Film Society

The Film Society's Spring programme will be—

9th Jan.—Hamlet.

23rd Jan.—Hiroshima mon Amour.

6th Feb.—The Naked Truth.

20th Feb.—The Third Man.

6th March.—The Importance of being Ernest.

Dramatic Society Nursery Productions

IT WAS WITH great interest that a large audience gathered in the recreation room of College Hall on the evening of November 23rd to see the Nursery Productions of the Dramatic Society. Three one act plays were performed offering ample scope for detecting talent amongst the newer members of the Society who had never before had opportunity to exhibit their skills before a Bart's audience. The idea was a novel one, and as such succeeded. There should now be little doubt, in the mind of the producer, who is likely to merit the distinction of appearing in the cast of the main production of the Society at the Cripplegate Theatre on February 20th and 21st, 1961. Not only did the Nursery Productions offer opportunity for the actors to shine, but talent was exhibited in many other directions contributing to the total success of the evening. Congratulations should go to all those who worked behind the scenes, to the providers of the most adaptable scenery and in particular to those who made the most of the necessarily limited facilities offered for such a production at College Hall. Mechanical difficulties were dealt with skilfully and those less capable of being overcome were accepted by a cheerfully tolerant audience.

The first play "Try it again" by J. B. Priestley was performed by a group of preclinical students who enthusiastically tackled something which they and the audience found somewhat oppressive. It is essential that a One Act play must hold the attention of the audience constantly within its grasp, but the acting, though vigorous, was ineffectual in conveying the meaning of the play as one assumes the author intended. Credit must go to Bruno Kastelitz who gave a convincing performance as Kramer, the stranger who endeavoured to disentangle the oh so familiar problems of domestic life as seen through the eyes of the playwrights. Rachael Fisher gave a promising performance as Helen, the intonations of her voice singling her out from the other members of the cast who unfortunately showed little variation in manner of speech and in gesture. The limitations of the stage may well have caused the poor positioning in the play, but could hardly be blamed for the self-conscious attitudes and mannerisms of the cast apparent to some extent throughout the evening. The choice of play was ambitious and was a welcome feature of this domestic trilogy in that it was a play with some purpose.

"The Birds of Prey", a comedy by Mabel Constanduros and Howard Agg, was received with great appreciation by the audience. Susan Williams exercised considerable talent in the portrayal of Mrs. Wiffin, the central character in the play, and one feels sure that she will soon become a familiar figure on the stage of the Cripplegate. John Graham Pole, though having only a small part to perform, did so well. All praise to the producer, Nicholas Lochlan, for this polished presentation.

"Love in a Suburb" by Philip Johnson, did not quite achieve the high standard promised by the previous play. Unfortunately the cast, composed this time of clinical students and members of the nursing staff, succumbed to one of the perils of clinical existence and the show went on despite the recent illness of three members of the cast. Diana Clark gave a brilliant performance as Queenie Tremayne and one found it hard to believe that she was not originally intended for the part, her gestures rarely failing to inspire laughter from the audience. Patrick Kingsley as the eager Tony Mortimer gave us some insight into his experience as an actor and Mike Stewardson tacked a difficult character study with imagination and zest, carrying with him sympathetic attention throughout his appearance. Despite this, the production on the whole appeared stilted and much of the acting wooden and unimaginative.

The evening passed quickly and pleasantly for those present and there is no doubt that as a social and constructive occasion it was a great success, although at times of doubtful artistic merit. The Dramatic Society is fortunate to have so many enterprising members and the success of the evening should be a great source of encouragement to those responsible for the main production next year. It was gratifying to see so many members of both the medical and nursing Staff present, and one feels sure that future productions of this kind will find little difficulty in attracting a similar response. A. C.

The Guinness Luncheon 1960

ON NOVEMBER 7TH, thirty students from Bart's walked through the gates of Guinness's brewery at Park Royal with somewhat greater alacrity than they had shown on entering the gates of Brighton six months earlier. This was the third day on which Guinness had entertained successful competitors of the 1960 Inter Hospitals London to Brighton Stroll.

Their pace quickened as they were directed to the Toucan Inn and on arriving there, those who had not already drunk their morning draught were surprised to be met by a rather large talking toucan, however, on closer examination, it became apparent that Mr. Alfie Howard, the Guinness Majordomo, was inside.

Once inside, all were soon draining the glasses of Guinness thrust repeatedly into their hands, but eventually the majority of the guests were persuaded to leave for a tour after the guide had promised a speedy return to the Inn.

The tour of the brewery was an impressive and extremely interesting experience for everybody and much surprise was expressed generally at the enormous scale on which Guinness is brewed and the "dairy cleanliness" of the whole factory.

Their palates thoroughly prepared by the sight of so much Guinness the party returned to the Toucan Inn, where they slaked their thirsts with quantities of assorted liquid refreshment.

The colourful menu, proclaiming such dishes as Weary Calf Steak with Blister sauce and Assorted Brighton Rock, hardly paid justice to the splendid meal which followed. Later in a flow of postprandial eloquence, no doubt enhanced by the excellent Port and during which Mr. E. Wood and Mr. G. Baker exploded the notion that brewers do not know any good stories; Professor Hazelwood of Guys, himself a successful competitor, said how impressed he had been whilst walking, by the tremendous spirit of camaraderie amongst students, who, in any context would have been the keenest rivals.

Late that afternoon the numbers in the Toucan Inn had hardly decreased and the general opinion was that it had been worthwhile walking to Brighton. Our hearty thanks must go to Arthur Guinness Ltd. for their splendid and unstinted hospitality. Next year I suspect they will see many familiar faces and I hope, many more new ones.

News in Brief

Sir Geoffrey Keynes will be giving the second Grey Turner Memorial Lecture for Durham University at Newcastle on 22nd February. The subject of the lecture will be " The History of Myaesthenia Gravis ".

On May 3rd, Sir Geoffrey Keynes will also give the Gideon de Laune lecture at the Apothecaries Hall. Subject: Dr. Timothy Bright, Physician to St. Bartholomew's Hospital.

Change of Address

MR. & MRS. JOHN HOSFORD'S only address will be: Carril, Reguengo, Portalegre, Portugal.

DR. A. GEOFFREY DAWRANT, 26 Boltons Court, 216-222 Old Brompton Road, London, S.W.5.

DR. R. KNIGHT, c/o Morwell Medical Clinic, Morwell, Victoria, Australia.

BRIG. J. E. SNOW, O.B.E., Echo Barn, Echo Barn Lane, Wrecclesham, Farnham, Surrey. (Farnham 460.)

Births

MACADAM.—On December 1st, in Buenos Aires, to Diana, wife of Dr. F. I. Macadam, a daughter (Margaret Mary).

MIDDLETON.—On November 23rd, to Jeanne and Dr. George Middleton, a daughter.

PHILIP.—On December 5th, to Julia and Philip Paton Philip, a son (Charles).

RIMMINGTON.—On December 3rd, to Peggy and Dr. Kenneth E. Rimmington, a son (Thomas Oliver Rahere), a brother for Noëlle and Robin.

Deaths

HAMILL.—On November 29th, John Molyneux Hamill, M.A., M.D., D.Sc., O.B.E., aged 80. Qualified 1904.

HAYES.—On December 10th, Dr. William Edward Hayes. Qualified 1921.

PATON.—On December 7th, Florence Paton, S.R.N., late of St. Bartholomew's Hospital.

SEYMOUR.—On November 28th, Dr. James Croley Seymour, aged 39. Qualified 1945.

SOME OF THE ADVANTAGES OF A VISIT TO A G.P.

by M. Millington

IT IS NOT generally known in the Hospital that facilities exist whereby students can spend a week or two with a general practitioner. The desirability of such a scheme would seem obvious, for although during student and pre-registration years it is possible to gain a fairly accurate picture of the various aspects of hospital practice, most gain only secondhand information, usually prejudiced, regarding general practice. Since the majority of medical graduates eventually enter general practice, it is strange how they can feel themselves capable of making such a decision, whilst so lacking in accurate information. Viewed this way, if medical education is to realise its aim of preparing students for the work of later life, there is obviously need for the inclusion of specific instruction in general practice in the medical course.

Much is written nowadays about the importance of treating the patient as a person, and not a collection of organs, each considered as a separate entity in itself. Indeed, like every reaction, over-emphasis tends in this direction at the present time, rather than the opposite of a few years ago, so that much otherwise good advice becomes platitudinous and hackneyed. Nevertheless, the psychological and social concomitants of physicall ilness are real problems, and a period in general practice helps one to appreciate them.

Another very useful feature is that a stay in general practice can serve to indicate to the prospective general practitioner those aspects of his undergraduate education which will be of most use to him later. A true picture of the incidence of disease may be obtained, in contrast to the artificial selection imposed by hospital entry. For instance, in the practice I visited, Weil's disease occurred as frequently as rheumatic fever, and although this may not be generally applicable throughout the country, one questions the brief mention of the former, to the exhausting teaching of the latter in hospital, as being not quite in true perspective.

Students tend to view Public Health and the administrative aspect of medicine, together with medico-legal matters, as not "real" medicine worthy of their attention. Yet, a considerable amount of a general practitioner's time is taken by these matters, so that again such a visit results in a change of emphasis, and the student thereafter may take account of them in his medical training.

Although not the main purpose of these visits, an appreciable amount of medicine is learnt, useful for the more immediate worries of examinations. Similarly, the opportunity of discussing all branches of medicine, as presented by the patient, in a short space of time with a knowledgeable and amenable person is one that does not occur during hospital training. Housemen are usually so busy, consultants too remote and unapproachable for really thrashing out a subject individually, and registrars a combination of both, that such discussion becomes especially profitable. In fact this was the nearest approach to an individual tutorial system I have met in clinical medicine, even though such a system would obviously be of great value should it exist in the hospital.

I have tried to show a few of the advantages of a brief visit to a general practice, but have not described the details of my visit, nor of the particular practice I visited, because they will obviously differ with each practice, but have tried to indicate the broader principles which are more widely applicable. It is for this reason that a week to a fortnight is the most advantageous length of time to stay, because the principles of general practice which emerge during this time, and whose impartation is the object of such visits, would later tend to be obscured in the mass of detail acquired by a more prolonged stay.

Finally, I should like to thank those who made my visit possible, and if all practitioners practice as high a standard of medicine as the one I visited I think there will be few students disillusioned by general practice.

A CASE OF AMYLOID DISEASE

By S. M. Watkins

AMYLOID DEGENERATION OF the kidney was first described by Rokitansky in 1842 as "Speckniere" or "bacon kidney". It is fairly uncommon as a clinical syndrome: only four victims were reported in this Hospital in 1959. All four were cases of amyloid secondary to chronic infection. One of them was of particular interest because of the multiple pathology and symptomatology, and the development of a rare complication.

Case History

Mrs. B., a housewife, sustained a fracture of the sacrum at the age of 12. The wound became infected, and the resultant abscess took 14 months to heal. The osteomyelitis recurred several times during adolescence and early adult life, with general malaise, fever, sacral pain, and pus draining from the rectum. She had two pregnancies: both children were normal.

In 1952 at the age of 32, she developed polymenorrhoea and menorrhagia. In 1957 she was seen again suffering from malaise, with headaches, anorexia, dyspnoea, and palpitations on exertion. On examination, the liver was just palpable; there was bilateral ankle oedema; and there was an erosion in the posterior wall of the rectum. Investigations revealed a severe anaemia, proteinuria, and azotaemia, with a fall in alkali reserve. A renal biopsy confirmed a diagnosis of amyloidosis. The treatment was an increase of protein and fluid intake, together with 40 m Eq. of sodium lactate daily. In May 1958, she had a radium menopause to stop the loss of blood.

One year later she was re-admitted, complaining of nausea, vomiting, headache, pruritus, and "misty vision". She had impaired powers of concentration. The blood pressure was raised, and there was bilateral Grade IV hypertensive retinopathy; left ventricular hypertrophy, oedema and a raised jugular venous pulse were also present. There was severe anaemia (which was treated by transfusions of packed cells), and acidosis (shown by the low alkali reserve). Her condition deteriorated rapidly and three weeks after admission she had a series of short convulsions lasting about a minute each, followed by a massive retinal haemorrhage. She died the same day.

Post mortem examination showed that death had been caused by the intracerebral and pontine haemorrhages. Other pathological findings were: old osteomyelitis of the sacrum, with fibrous adhesions to the rectum; left ventricular hypertrophy, with mild atheroma of the coronary vessels; a foraminal pressure cone in the brain, oedema of the legs and serous effusions of the pleurae and peritoneum. The kidneys were contracted (40 and 45 grams) and showed ischaemic scarring; the cortex was reduced in thickness, and the vessels and Malpighian bodies were prominent; iodine staining for amyloid was positive. Microscopically there was exten-

Summary of Pathological Tests

	Age	*Blood Urea mg %*	*ESR mm/hr*	*Hb %*	*W Bc /cu mm*	*BP*	*Serum Proteins Gm %*	*Urine Proteins Gm %*	*Serum Cho-lesterol*	*Alkali Reserve m Eq/l.*	*Serum Sodium m Eq/l.*	*Serum Cl m Eq/l.*	*Serum K m Eq/l*
	21	32	43	60	30,800	108/80							
First Pregnancy	22		64	96		122/84							
Second Pregnancy	27			70	6,900	110/70							
At Time Of Diagnosing Amyloid	37	220	46	46	11,000	150/80	A. 3.3 G. 2.0	4.8	280	16.3	133	105	5.9
Last Admission	38	300	52	36	4,500	230/130				25.7	130	103	4.5
On Day Of Death	38	256				220/140				17.2	117	83	4.7
(Normal Range of Values)		15–40	4–7	82–105	4,000 –10,000		A.4–6.7 G.1.2–2.9	0	200–300	24–34*	137–152	96–106	3.9–5.6

sive amyloid infiltration, which in places had formed large focal collections which were gradually obliterating the renal architecture. The spleen was congested and contained amyloid infiltration, as did the adrenals. The ovaries had similar deposits in the vessel walls; there were also some follicular cysts, and an old haemorrhagic corpus luteum. The lungs were congested and oedematous.

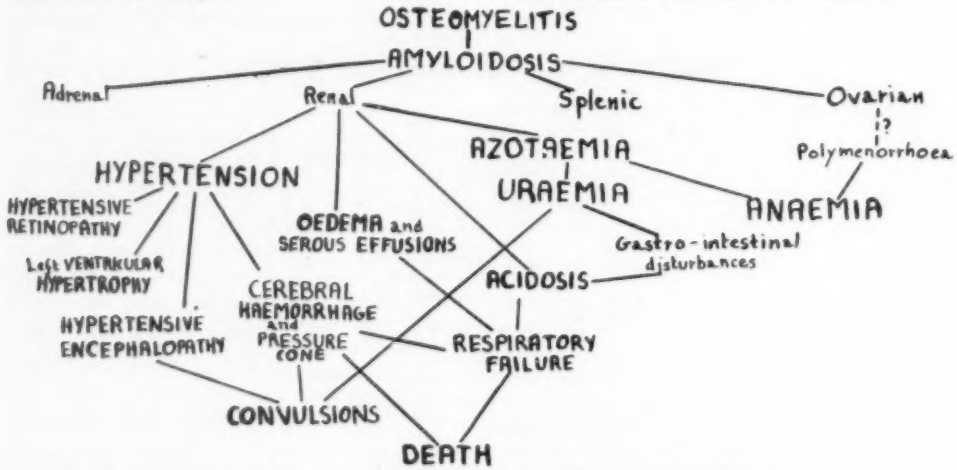
This, then, is a case of amyloidosis secondary to osteomyelitis. Hypertension, which occurred in this patient is an uncommon complication of renal amyloid (in 1950, Leard and Jaques could find descriptions in the medical literature of only 40 cases, all of whom, like Mrs. B., had contracted, ischaemic kidneys). The nature of the relation between the two conditions is uncertain. The hypertension in its turn, caused Grade IV retinopathy (with misty vision), and left ventricular hypertrophy. Finally it contributed to the convulsions and to the terminal cerebral haemorrhage.

The renal damage in due course gave rise to proteinuria and azotaemia, with mild hypoproteinaemia (especially albumin), and a slightly raised blood cholesterol. "The loss of protein in the urine . . . is probably a major factor in the accompanying hypoproteinaemia, the reversal of the albumin/globulin ratio, and probably, by mechanisms as yet unknown, the hypercholesterolaemia (Allen). With respect to the latter, Fishberg has ingeniously suggested that the raised blood cholesterol (which is far more marked in fat patients), represents the mobilisation of body fats, in an attempt to restore the osmotic pressure of the blood, which has fallen as a result of the urinary protein loss.

The azotaemia depressed the marrow function, contributing to the patient's severe anaemia; another contributory factor was the polymenorrhoea (which may perhaps have been in some way related to the ovarian amyloidosis). Later, there developed the full clinical picture of uraemia, with weakness, nausea, anorexia, vomiting, headache and pruritus. The gastro-intestinal disturbances, together with renal failure eventually caused a metabolic acidosis.

The terminal convulsions were probably due to a combination of uraemia and hypertension, precipitated by the cerebral haemorrhage. Finally, death was due to a combination of these latter factors, together with respiratory failure.

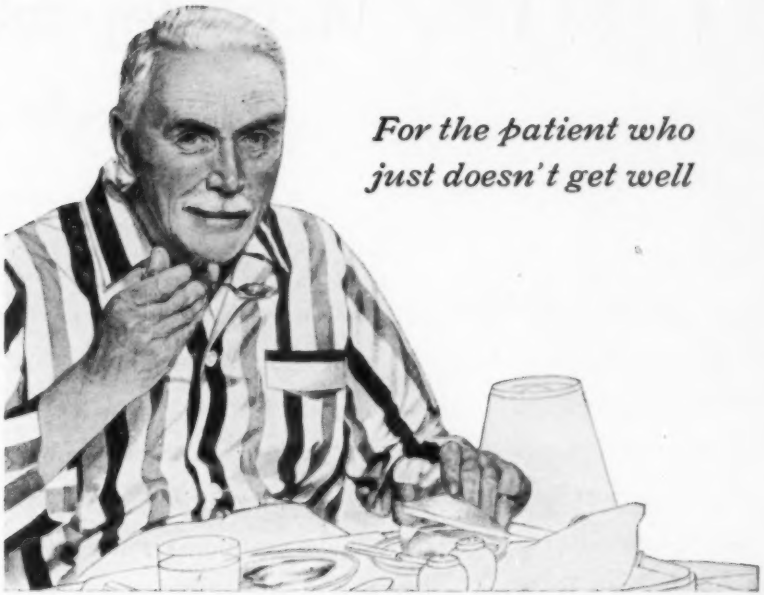
The clinical and pathological history is summarised in the following diagram.



The Problem of Diagnosis

The diagnosis of renal amyloidosis from other forms of nephrotic syndrome is often difficult, for in the early stages, the conditions are clinically identical. Congo red tests and tissue biopsies are, of course, diagnostic, but they are rarely performed in the early stages of any renal disease. As in Mrs. B.'s case, the most valuable early clue is a history of chronic infection preceding the renal signs, though it is not present in every case.

The first differentiating symptom is often polyuria. For in nephrosis, increasing glo-



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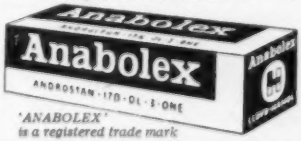

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LIFE

merular damage leads to a decrease in GFR (and hence a tendency to oliguria and diminishing proteinuria) whilst in amyloid degeneration of the glomeruli, the GFR and proteinuria are progressively raised. At the time of diagnosis, Mrs. B.'s daily urinary output varied between 1¼ and 2½ litres, which was certainly suggestive of amyloid rather than other types of nephrotic syndrome. Another clue is the urinary albumin level, which is relatively lower in amyloidosis than in other nephroses. Geill noticed that the urinary albumin fraction falls further still in the terminal stages of amyloid disease, and that a level of less than 60 per cent of the total urinary protein indicates a poor prognosis.

These few differentiating features are mainly of academic interest, for the treatment and prognosis of all forms of nephrotic syndrome (including amyloid disease) are the same. However, the importance of early diagnosis of amyloid disease has often been stressed in the interest of those rare cases in whom intensive treatment of the underlying condition may lead to a regression of the amyloid. Mrs. B. on the other hand, is an illustration of the vast unfortunate majority in whom the amyloidosis, though fairly easy to recognise, appears only when the chronic infection has been present for many years and has failed to respond to treatment.

As yet, there is no treatment for amyloid disease. Prophylaxis is surely the answer to the problem; and to this object a study of the pathogenesis of the disease is no doubt an important approach.

The Pathogenesis of Amyloid Disease

(a) Circulating Globulins

The aetiology of amyloid disease is a matter of controversy, and is complicated by the fact that, although most cases are secondary to infective and other conditions, a small number are apparently primary or "idiopathic". The commonest underlying conditions are chronic suppuration, tuberculosis and syphilis, but it occurs also in a small proportion of cases of multiple myelomatosis, Hodgkin's disease, leukaemia, gout and rheumatoid arthritis.

In early experiments it was found that repeated injections of living or dead bacteria, or bacterial toxins, produced amyloid disease in mice; and that prolonged feeding of cholesterol to rabbits caused hyperglobulinaemia, and sometimes amyloidosis. In 1923, Kuczynski produced hyperglobulinaemia and amyloid in mice by repeated injections of sodium caseinate, and concluded that the amyloid deposition was in some way the direct result of increased amounts of circulating breakdown products. However, in 1936, Jaffé showed that the amyloid changes were proportional to the number of the first few injections only, after which there was no quantitative relationship. He concluded that the amyloid changes are the result of an acquired hypersensitivity to the foreign protein; excess circulating antibodies could indeed favour the deposition of complexes containing globulin (e.g. amyloid material) and recent experiments have shown that this process is accelerated by gamma-irradiation (Lesher et al.). The amyloidosis secondary to chronic infection may thus be explained in terms of acquired hypersensitivity to the organism (or to one of its derivatives). Similarly, this could account for the amyloidosis associated with rheumatoid arthritis, for as Glynn says: "haemolytic streptococci are capable of adsorbing minute amounts of non-antigenic polysaccharides, and converting them to complete antigens". He suggests that this may be the immunological basis of the rheumatic lesions, in which, a tissue component constitutes the non-antigenic hapten. It is possible that the same immune reaction could also be responsible for the amyloidosis. If this were true, it would be a case of two different degenerative lesions resulting from a single immunological factor, rather than one lesion being secondary to the other. In this case one might expect that any agent which produces a cure or remission of one condition should do likewise in the other. Parkins and Bywaters have observed precisely that: in cases of amyloid with rheumatoid arthritis, remission of the latter during steroid therapy was accompanied by regression of most of the clinical signs of amyloid, although the Congo red test remained abnormal. Relapse of the arthritis was associated with a rapid return of the splenomegaly and proteinuria, and the presence of amyloid was confirmed by biopsy. The temporary symptomatic improvement of both conditions is certainly not a cure; it may be a combination of the specific action of steroids in rheumatism, together with a non-specific

effect on glomerular filtration (it has been shown that urinary fluid and protein loss could be diminished by steroids, which decrease glomerular permeability). However, the complete disappearance of the hepatosplenomegaly as well as the proteinuria suggests that something more has happened: perhaps the remission of both conditions represents an attack by the steroids on the common underlying cause, thereby allowing temporary improvement of the structure and function of both the rheumatic joints, and the amyloid viscera. The fact that steroids are beneficial in so many types of immunological disorders would lend support to such an idea.

What, then, of primary amyloidosis? Jaffé, firmly convinced by his explanation of an immune response, suggested that it might be due to a pathological hypersensitivity to the foreign proteins, which result from abnormal intestinal permeability, abnormal liver function, or other disturbances of protein metabolism. This could be true, though he offers no evidence to support his theory. One could well suggest other causes: for example, an immune response of the rheumatic type (outlined above), without the associated rheumatism; for, by this theory of a common underlying cause, one could expect amyloid disease without rheumatism, just as one so often sees rheumatism without amyloidosis. Another possible source of antigen for an immunological reaction could be from extensive tissue damage: for example, the young man described by Muerhke *et al.* had been severely burnt in childhood: could his amyloid degeneration have been initiated already at that time, when his body was reacting to the denatured proteins? Or perhaps it may be possible for amyloid to develop in an organ which has suffered a prolonged, low-grade, symptomless infection (a combination of direct toxic effects with local hypersensitivity). However, these are but unsupported suggestions. In any case, the multiplicity of the known conditions underlying amyloid, suggests that several different antigen-antibody reactions may lead to the same pathology.

(*b*) *Tissue changes*

The ground substance of connective tissue is composed largely of hyaluronic acid and chondroitin sulphate, and, according to some workers, it constitutes the "metachromatic pool" from which elastic and fibrous structuser are formed and to which they eventually return in the course of ageing. It has been suggested that the amyloid material arises from connective tissues. Is it possible then, that in response to an antigen-antibody reaction, amyloid (i.e. chondroitin-sulphate-protein complex) deposition is an abnormal, exaggerated and accelerated form of the normal degenerative process of ageing, in which the elastic tissue is gradually replaced by ground substance (or "returned to the metachromatic pool")? Lesher *et al.* whilst agreeing with the principle of amyloid formation from connective tissue, have pointed out that the kidney has very little connective tissue, and therefore the amyloid must be synthesised in numerous organs, and carried from the more productive areas to other sites by the plasma. Indeed, a rise in serum chondroitin sulphate has been found in amyloidosis. (However, this rise occurs also in other types of renal disease, so that this non-specific change could perhaps be the result, rather than the cause of renal damage.) Recently (1955), Block *et al.* have found a relation between an electrophoretically abnormal circulating protein-polysaccharide, and amyloidosis.

It is possible that a combination of abnormal circulating materials and tissue changes is required for amyloid deposition. The long continued stimulus of abnormal substances would cause a large increase in circulating globulins (antibodies) or, as Pépin describes it in his excellent review "une vague d'hyperglobulinémie". The globulins would readily be precipitated in the deranged connective tissues and attract other substances from the circulation, notably lipids, cholesterol and chondroitin sulphate.

One last consideration: why do some animals develop amyloid disease, whilst others, under the same conditions, do not? Krawkow, in 1896, produced amyloid in rabbits by the injection of Staphylococcus aureus, but found that some of the rabbits failed to develop amyloid, although during life they had similar symptoms and died just as quickly as those that did develop it. He concluded that the difference in reaction was due to "toute une série de conditions individuelles". Just what those individual, constitutional conditions are is still unknown. However, recently, Peräsalo *et al.*, experimenting with sodium caseinate injections in

animals, found that various "stress" conditions (heat stress, infection, cortisone and ACTH injections etc.) accelerated the appearance of amyloid, and concluded that there may well be a relation between " stress" and amyloid deposition. Further investigations are required in this field.

These experiments and theories are mere searchings in a most confusing field of facts and figures. Yet they are of great importance, for only in the understanding of the aetiology is there hope for the prevention and cure of this fatal disease.

Acknowledgments

I should like to thank Dr. Bodley Scott for permission to publish this case and for his interest in the work; and Dr. Matthias, Dr. Lehmann and Dr. Stansfeld for their encouragement and assistance.

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EXTRACTS FROM A REPORT ON AN UPJOHN FELLOWSHIP 1960

By J. B. Bamford, M.R.C.S. (Eng.), L.R.C.P. (Lond.), D.A.

IN THE EARLY part of 1960, Dr. Bamford was awarded an Upjohn Travelling Fellowship, in the course of which he was able to spend two weeks at his old Hospital. Of the four subjects which Dr. Bamford selected for his attention, and on the basis of which he was awarded the Fellowship, the last is:

"To do my part in meeting as many of the young doctors as well as my contemporaries who are now on the senior staff, and to persuade them that the ART of medicine must not be forgotten in this great advance of scientific medicine. To entertain them and encourage the young ones to WANT to become good General Practitioners. . . ."

I had a wonderful opportunity not only of talking to consultants, but also to registrars and housemen, especially over lunch and tea. They all welcomed one and were not only prepared to help one by answering questions, but were also very keen to hear about General Practice.

I was most impressed when sitting in with one surgeon seeing his follow-up cases, some of whom he had not seen for many months. No patient was allowed in until he had looked through his notes and refreshed his memory of the case. Every patient was welcomed, not only by name, but by a shake of the hand across the desk. The pleasure this efficiency and friendliness gave to the patient was obvious. It made me think of times when I am rushed and call out crossly "Next please" in my surgery. A salutary lesson.

I know bad doctors can shake hands with patients. I also know that some doctors think they are so clever and can get to the top without politeness, and some do. But why not combine both. I was delighted to see the art of medicine was still considered important.

When sitting in with a physician, another point was brought out. I noticed he was signing a patient up for three different kinds of Tablets. I enquired, "Do you tell the General Practitioner what tablets you have given the patient?" His reply was, "Yes, usually". Then he asked me, "Do you always tell the Consultant, when you refer a patient to hospital, what tablets the patient is having, or has had recently?"

The next patient came in and her opening remarks were: "The tablets my own doctor gave me last week have made me so *much* better!" She had no idea what they were, nor had the consultant. It made me think.

From the above notes, it may look as if I did no real work on research. I think that is probably true, but I have never had such a stimulating fortnight, and except for a little reminiscing, I talked shop most of the time, until bedtime, helped of course by good Claret and Cockburn's '27!

I now add a few notes on a few subjects that are of interest to many General Practitioners.

Post-graduate Study for General Practitioners

I would like to see a Scheme, in addition to all that is arranged now, of Senior Registrars spending one week, every three or four years with a General Practitioner who would be willing to entertain them. The registrar would have to be prepared to talk shop and, I feel, would be able to help one to keep up to date and, at the same time, see several cases of medical interest, and see what the General Practitioner "wants" from a consultant or hospital. All registrars to whom I spoke were greatly in favour of the Scheme. The only people who might object would be the Consultants who would lose their Right hand man for seven days! I still think that General Practitioners' courses and "get-togethers" are important, and should be continued.

General Practitioners and Teaching Hospitals

I feel that the Student and young Houseman still do not have a high opinion of the average General Practitioner. I think their experience in this field is limited, and often coloured by a very few bad General Practitioners who refer many cases to hospital without examining them!

I feel that it is imperative for the welfare of the whole profession that this state of affairs should be improved.

I have never had anything but the greatest courtesy and help from Consultants, even when I have "missed" an obvious diagnosis.

I suggest that all teaching hospitals should appoint a good General Practitioner to each of their eight or ten Clinical firms.

The General Practitioner should be prepared to be at the hospital for one half day each month. He should go on a round and be allowed to talk to the Registrars and Housemen and Students for 10–15 minutes at the end of the round. He would provide the personal link with the firm and general practice. Registrars, housemen, and students would probably then welcome an invitation to see general practice at first hand.

I fully realise that the Dean of my old Medical College is conscious that the curriculum is already over full, but those of us who have sons, or know sons of friends doing medicine feel that 15 minutes a month could easily be fitted in, and that an odd half day during their holidays would be welcomed, if the opportunity was offered and organised. I feel that the advantages of this simple scheme are enormous, and would help to raise the standard of medicine, and help to narrow the gap between the General Practitioner's services and the Hospital services.

General Practitioners and Hospital Beds

I feel that this is a very difficult problem. Personally, I feel that it would be wrong, at the moment, for a General Practitioner to be in charge of beds in General Teaching Hospitals. I do, however, feel strongly that a start should be made for General Practitioners to be in charge of hospital beds for the Chronic sick. The following is a short memorandum on the subject.

MEMORANDUM

on General Practitioners being in charge of Patients in Hospitals for the Chronic Sick.

General

I feel that a wonderful opportunity to improve the N.H.S. in every way would be to allow more G.Ps. to be in charge of Beds in those hospitals which care for the Elderly Chronic Sick (i.e. the old workhouses and Infirmaries now converted to Hospitals). In large towns where there are wards (or blocks) of large hospitals devoted to the Elderly Chronic Sick, local G.Ps. should be encouraged to be in charge of these wards. There are many hospitals for Chronic Sick where one G.P. looks after over 200 beds, surely too many for one man.

Advantages

A. To Patients

1. It would lessen "the shock" to a number of old ill people if they knew their own doctor (or a doctor of their choice) would continue to look after them when admitted to Hospital.

2. In some cases where one knows the background at home, it might be easier to get them home after they are over the critical period of their illness.

3. Usually it is easier and better for a Doctor who has known his patients for a number of years to treat what is possibly their last illness.

4. I feel that it is wrong that because a patient is poor or ill that he should be deprived of his or her Doctor of choice. This is the only category of patient (except those in the Services) which cannot choose its medical advisers.

B. To the Service as a whole

1. G.Ps. have been clamouring for years for more G.P. beds. Surely this is one way of implementing it.

2. The Nursing Staff would benefit by meeting different doctors with different but equally good methods. Anything to improve the "nurses' lot" in this type of hospital is worth-while.

3. There would be a quicker turn-over of patients which would tend to cut down the appallingly long waiting lists, as doctors would do their best to discharge their patients home to admit more of their urgent cases.

C. To the General Practitioner

It would bring G.Ps. into contact with one another and with consultants, thereby raising the standard of medicine. It would help to develop The Cottage Hospital attitude for patients and staff, although it is for the Chronic Elderly Sick, and help to remove the stigma of Workhouse, Infirmary, etc.

Disadvantages

I presume that these would be purely administrative, but I feel could quite easily be overcome. If each G.P. was given, say, 25 beds, the number of G.Ps. on the staff limited to this proportion, it would give every keen and good G.P. something to work for to be appointed to the Staff. I suggest payment on the Cottage Hospital Scale, if payment is considered necessary.

Merit Awards for General Practitioners

I feel that a Scheme could be worked out on the following lines. That age and experience all help to make a good doctor, and over a period of twenty years, the patients have a very good idea of who is a GOOD General Practitioner.

Bearing in mind the above points, I suggest that Merit Awards should be given for 5 years and only considered for those General Practitioners who have been in practice for 20 years, and aged between 55 and 60 years and whose lists are average or above the average for the neighbourhood.

I think General Practitioners should be asked to apply for them in the same way as they apply to become a Trainer, in the present Trainee Assistant Scheme. In spite of talk of abuse of the Trainee Assistant Scheme, there are very few people who can quote actual cases of any number where it has been abused.

Sir Will Spens, who personally suggested the Trainee Scheme, meant it as a Merit Award for General Practitioners, and that for six months the trainer should train a young doctor, passing on useful information etc., and then the final six months having more time off himself and leaving his Trainee to take some of the work off his shoulders. I do not mean going off on holiday and leaving the Trainee single handed. I have met many Trainees and have yet to meet one who was dissatisfied with his or her Trainer.

QUOTE

Transactions of the 19th Conference on the Chemotherapy of Tuberculosis, Cincinnati

THE SECOND ANNOUNCEMENT I would like to make, pertains to a mouse who was taken out of the laboratory at Cape Canaveral and tested for radiation, had electrocardiographic tracing, had his urine tested, his blood checked, and his fur checked. He was then put into the nose cone of a missile, and he had electrodes strapped on to him, and a movie camera was turned on him, and a recording device was put on, and the missile was then shot 5,000 miles down the Atlantic about 200 miles up. The nose cone separated and fell into the Atlantic Ocean, and the destroyer went out, "frogmen" dived in and recovered the nose cone. The nose cone was put on the destroyer. The destroyer raced back to Cape Canaveral. The mouse was taken out of the nose cone, was taken back to the laboratory. His recordings were all analyzed. His blood was again checked. The urine was again checked. The radiation was checked. His fur was checked. And finally he was put back in the cage. At which point, all the other mice raised up and asked him how it was. And he looked at them and said, "Well it was pretty bad, but it sure beats cancer".

BOOK REVIEWS

MACKIE AND McCARTNEY'S HANDBOOK OF BACTERIOLOGY. A Guide to the Laboratory Diagnosis and Control of Infection. Edited by Robert Cruickshank, M.D., F.R.C.P., D.P.H., F.R.S.E., and Members of the Staff of the Bacteriology Department, University of Edinburgh. Tenth Edition. pp. xi + 980. 40s. **E. and S. Livingstone, Ltd.,** Edinburgh and London.

For many years, Mackie and McCartney has been the standard manual in bacteriological laboratories, and has been chiefly concerned with practical methods and not a great deal with theory. This new edition has undergone a change. It has new authors, being compiled by Professor Cruickshank and seven others from the Department of Bacteriology, University of Edinburgh. It has been extensively re-written and includes much new material. Viruses, for instance, now occupy eight chapters instead of one as in the last edition. The test is somewhat less arbitrary and the theoretical background is more fully stated. There is no doubt that pathologists will welcome this edition as warmly as its predecessors. Because of its wider scope it should be of greater service to others. R.S.A.

SOCRATES ON THE HEALTH SERVICE. Published by the Lancet. 5s.

Collections of articles that have appeared in Journals, when reprinted in book form, are always intimidating to anyone who approaches them fresh. The cautious reader might well fear the worst from this collection of dialogues which first appeared in the *Lancet Dialogues* with too much wit, too much intellect, and by an anonymous author, who the editor assures us is well known: the whole conjures up the thought of reading something like an anthology of the more esoteric of the *Spectator* competitions. But once the Socratic method has been braved, such fears prove unfounded. Should the reader persevere, he will find enough wit and intellect to stimulate his own thoughts, enough wisdom to satisfy and arguments to arm him for discussions on a number of controversial subjects concerning both doctors and laymen. Among the subjects dealt with in this collection are nuclear warfare, medical education, committees, birth control, punishment and crime. To those who already know these dialogues, this little book provides a useful collection so that they may be read again, and enjoyed, at leisure. R. S. D.

MARY, QUEEN OF SCOTS: THE DAUGHTER OF DEBATE by Sir Arthur Salusbury MacNalty. London, **Christopher Johnson,** 1960. 247 pp. 21s.

The tragic story of Mary, Queen of Scots has been the subject of numerous biographical studies, and Sir Arthur MacNalty here stresses the medical aspects of her hectic but brief career. A chronic sufferer from gastric ulcer and rheumatism, the subject of several severe mental disturbances, in addition to numerous other illnesses, she would appear to have been the victim of circumstances in a very turbulent period.

Sir Arthur has previously given us remarkable studies of Henry VIII, Queen Elizabeth, and the Princes in the Tower. In this well-documented survey of the life of a queen who was executed at the age of forty-four, we trace the fast-moving details from the time of her birth to her execution. Sir Arthur's researches throw fresh light on the events of the sixteenth century, and we will now have even greater sympathy for Mary, Queen of Scots, the tool of ambitious men. J. L. T.

LEWIS'S MEDICAL, SCIENTIFIC AND TECHNICAL LENDING LIBRARY, including a classified index of subjects. Supplement 1957–1959. London, **H. K. Lewis,** 1960. 306 pp. 10s. 6d. (Subscribers, 5s.).

This latest supplement to Lewis's main *Catalogue*, which covers the period up to the end of 1956, includes additions up to the end of 1959. An invaluable reference tool for users of the Lending Library, it also provides details of latest editions, including prices. The main body of the supplement is arranged alphabetically by authors, but there is a useful index of subjects. J. L. T.

POCKET PRESCRIBER. Published by Cruickshank. 6s. 17th Edition.

For its size, this book contains a remarkable amount of Therapeutic Information.

The first section of General Prescriptions contains many interesting old mixtures, a considerable number of them must be of doubtful value except, perhaps, that they satisfy the patient's demand for "a bottle". The emphasis given to remedies for some conditions is often unusual, e.g. Parredilych and Barbitone head the list of treatment for insomnia. Gold is discussed in detail for the treatment of Rheumatoid Arthritis, while aspirin gets only a passing mention. The treatment of vomiting with small repeated doses of iced Champagne is an attractive idea, but must be rarely practicable.

There is a useful section consisting of an abbreviated list of drugs for the National Formulary, followed by a list of proprietary drugs giving their official names, instructions and dosages, and finally various tables.

It is unfortunate that the relative points, side effects and tonic effects of the various drugs have not received more attention.

This may well be a useful pocket reference book for a busy General Practioner, but it cannot be recommended as a short cut to Therapeutics for Students. T.W.G.

REALLY NURSE by Roger Brook. **Published by Souvenir.** 6s.

This is a light-hearted book for casual reading. The classified headings just save it from being a list of howlers made by student nurses in examination papers. It should have a wide appeal in the nursing profession, nostalgic and reminiscent for the veteran, stimulating and mirth provoking for the newly qualified and to the student a cheerful warning of pitfalls to be avoided. Its appeal will extend beyond the hospital walls to anyone seeking an inexpensive gift. It could be an entertaining addition to any bookshelf. The illustrations by T. Birdsall are clever and amusing. M. S. S.

SPORTS NEWS

SPORTS FIXTURES, FEBRUARY, 1961

Date	*Men*	*Ladies*
February 1st	A.F.C. v. Royal Dental Hospital (A)	Lacrosse v. Guy's Hospital (A) Hockey v. Guy's Hospital (A)
February 4th	R.U.F.C. v. O.M.T. (H) H.C. on Cambridge Tour A.F.C. v. St. George's Hospital (A)	Hockey v. Wimbledon (A)
February 8th		Lacrosse v. Queen Mary College and University College (H) (Cup)
February 11th	R.U.F.C. v. Esher (H) H.C. v. Kings College, Cambridge (H) A.F.C. v. Old Cholmelians 2nd XI (H)	Hockey v. Goldsmith's College (A)
February 15th		Lacrosse v. Reading University (A)
February 18th	R.U.F.C. v. Metropolitan Police (H) H.C. v. Orpington (H) A.F.C. v. Trinity Hall, Cambridge (H)	Hockey v. St. Mary's Hospital (H)
February 22nd		Hockey v. Reading University (A) Lacrosse v. Royal Holloway College (A)
February 25th	R.U.F.C. v. Oxford University Greyhounds a.m. (H) H.C. v. St. Mary's Hospital (H) A.F.C. v. Guy's Hospital (H)	Hockey v. Royal Holloway College (H)
February 26th	H.C. v. Bandits (H)	

Sports View-point

"Thoughts of a Left Wing"

AS I STAND here—in the driving rain, temperature just, and only just above freezing—soaked, muddy (watch those spots in my eye—"Cast not out the beam in thy brother's eye etc."), the water slowly oozing over, and into, my expensive boots made in the other "Ancient Univarsity" and . . . wait . . . oh a movement, the ball is heeled (after sixteen successive attempts to get the ball past the prop have failed) scrum-half to fly-half and . . . but no—he's kicked back into touch . . .

Sorry where was I? . . . Oh yes . . . waiting. Well I wonder why am I here. My thoughts wander to another very gallant gentleman—Sir Nigel Molesworth, who has written on the same subject:

"Headmasters hav to hav some sort of excuse for games so that they can drive all boys and masters out into the foul and filthy air while they stir the coals into a blaze and settle down with one of the gangster books they have confiskated. In the last five minits they appear on the touchline and shout GET INTO HIM MOLESWORTH, GET INTO HIM it is all very well i am cold and covered with mud, the only thing i want to get into is a bath ha-ha!"

Now, unlike brave Sir Nigel, I've only myself to blame—or have I? Let's keep in line with my contemporaries and blame someone, something else—commonest things first of course. Freud—ah, now there's a possibility—what about my intra-uterine existence (ugh! what a sordid idea—perish the thought of me as a foetus). Think again . . . oh no hang on a moment . . .

Some silly fool in the opponents (by now they look exactly the same as us) has kicked ahead and the ball has gone and landed straight in the wettest part of this bog—and I shall have to be heroic (ha!) and fall on it . . . oh . . . How foul! And the mud smells just like the Roman Baths (at Bath of course) or like sewage—perhaps they manured the field with human . . . no they only do that sort of thing in uncivilised countries (to whom we used to send gun-boats regularly). And we are civilised aren't we (Welfare State and Tommy Steele!)?

To return to my monologue. Why exactly am I here? God may know the number of hairs on my head, but I bet he doesn't know why I am here (though since I haven't counted recently, and he presumably has, he is obviously in a better position to judge). Let's be fair! After all remember I'm British and all that (gun-boats again).

Perhaps that's why I'm here . . . No that won't do. We are a logical nation (that's why we say how wicked the unions are, and

then promptly go on strike with some bolsky —yea Brothers I use the word deliberately— capitalist says Mr. Cousens is a wicked man).

Why the . . . (can't use the word now— its so vulgar, everyone has been using it since the trial) am I here? . . .

Sorry for the delay, stupid full-back (ours) went and threw me a pass across the field— nearly dropped the damned greasy object— then moment of glory, I caught it and rooted it into touch; and all but eviscerated the President standing on the touch line (just to cap his afternoon!).

To return . . . no it's finished. Sorry. I shake my opposite number by the hand, "Good game—well played you deserved your win" (liar—that penalty was no more "foot-up" than the gymnasium over at Charterhouse is clean?).

Ah well—there's always the shower . . .

Sat., Dec. 3rd

1st XV v. Old Cranleighans. Lost 0–3.

Old Cranleighans won this game by the only score, a penalty goal, kicked early in the first half when they were playing with the wind and the slope. For the rest, the appalling conditions ruled out any constructive back play with the result that the match developed into a series of forward skirmishes between the twenty-fives. Jennings and Smart, with vigour undiminished by the previous night's Rugger Ball, toiled hard in the loose and Peek at scrum half handled and passed the very slippery ball with extreme skill.

Team. Ross, Burbridge, Letchworth, Niven, Jeffreys, R. R. Davies, Peek, Shearer, Gurry, Knox, Doran, Smart, R. P. Davies, Jennings, Halls.

Sat., Dec. 10th

1st XV v. Rugby. Lost 0–6.

Rugby came to Chislehurst on a dull, but dry afternoon and proceeded to score two forward tries without reply. However, it was not until late in the second half that their powerful pack achieved all-round domination. Both the Rugby scores followed forward rushes in the home twenty-five and indeed there seemed to be a premium on tackling and falling amongst the Hospital pack at times.

Outside, R. R. Davies frequently ran or kicked Bart's out of trouble and his tackle of the largest Rugby forward at the corner flag was particularly memorable. The three-quarter line contrived an overlap on occasions but lack of real speed prevented these opportunities being converted into tries.

Team. Ross, Burbridge, Letchworth, Niven, Jeffreys, R. R. Davies, Peek, Shearer, Gurry, Knox, Orr, Smart, R. P. Davies, Jennings, Halls.

Wed., Nov. 30th at Chislehurst

Bart's 2nd XI 4 Guy's 2nd XI 3.

This was a memorable game, deservedly won by Bart's. Despite the fact that they had only ten players, Guy's went into an early 1–0 lead. However, Walker soon equalled the score with a good goal. Guy's fought back and eventually went into a 3–2 lead, but goals by Choonoo (2) and Phillips ensured victory for the hospital. Gardos and Beecham, the latter wearing boots at least three sizes to large for him, played very well throughout. Further, the dislike for the opposing goalkeeper shown by Chant was noteworthy. In all, a very enjoyable game against more experienced, but less persistent opposition.

Team. N. Jones, A. C. Howes, I. R. Smith, J. Cannan, G. Gardos, H. Beecham, P. Stanley, R. Choonoo, H. Phillips, H. Walker, A. D. B. Chant.

Sat., Dec. 10th at Chislehurst

Bart's. 1st XI 4 Old Josephians 5.

Bart's were handicapped again by only having ten men. However, with a little more persistence, they might well have won this game.

At half-time, the score was 5–1. Two of the opposition goals had been virtually scored by Bart's players, for which only one of those players apologised to his team-mates.

In the second half, the hospital fought back well with goals from Choonoo (2) and Davies. Unfortunately, this effort on the part of Bart's came just a little late. Phillips scored Bart's other goal, and Hudson was a tower of strength at half-back.

Team. J. Spivey, G. Haig, T. Herbert, J. Davies, P. Savage, M. Hudson, E. Manson, R. Choonoo, H. Phillips, N. Davies.

Swimming Club

THE AMBITIONS WITH which the club started this season have not been realised. Two teams entered the United Hospitals'

Water Polo Leagues, one in each division. With all last year's players and a few promising freshers it seemed that Barts had a good chance of winning both divisions. However, this was not to be, and although the first team did lose two matches which could have been won, St. Mary's Hospital, much strengthened this year, did deserve to win two well fought matches by the narrow margin of two goals each time.

The second team, when all are present, are certainly among the best in the second division.

On December 5th and 6th, a swimming team was entered for the University Swimming Championships and in January 1961, the University Water Polo League commences. Two teams will be entered for the first time. The first team defend the high reputation which it earned by finishing third in the first division, and is determined to beat St. Mary's as it did last year.

RESULTS

United Hospitals' Water Polo League

	Played	*Won*	*Lost*	*Drawn*	*Goals For*	*Goals Against*
Division I						
Barts I	10	6	4	0	82	59
Division II						
Barts II	8	4	3	1	17	9

(Time: Saturday 3.30 p.m. —
Place: Some wet and windy environ of London)

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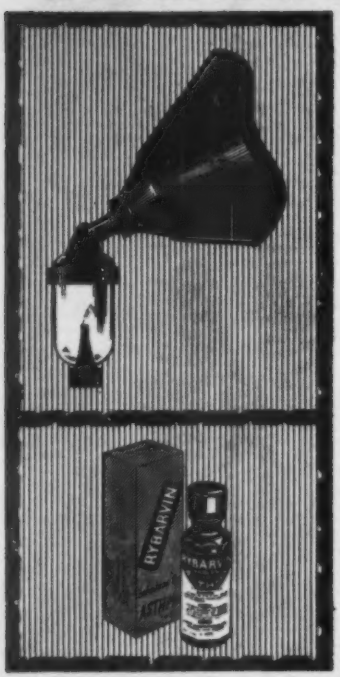

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